Equity, Equal Opportunities, Gender and Organisation Performance

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INTRODUCTION

This paper has attempted to cover a very large terrain – success has been limited. There are large gaps in coverage, with a bias towards advanced market economies (particularly the United Kingdom (UK), where equal opportunities initiatives in the health sector abound) and towards nursing and medicine. Very little published or "grey" literature was found on low or middle income countries. A mailing to contacts in different countries produced little of direct relevance. Some employment equity policies are sectorally generic and can therefore be considered to cover other kinds of health staff. However, much of the debate is focused on single occupations/professions.

CONCEPTUAL AND PRACTICAL APPROACHES TO EQUITY IN EMPLOYMENT POLICY

Arguments for and against equity measures in employment policy

There is no universally agreed view on either the desirability or the cost-effectiveness of policy measures to promote greater equity/reduce discrimination in labour markets. Bennington and Wein (1) give a useful summary of the main arguments. Neo-classical economics provides the core arguments against such measures, arguing that in a competitive market it is illogical for employers to discriminate against certain types of people on the grounds of personal taste or prejudice since this will affect productivity. The market is thus a self-regulating mechanism that does not require external interference. Indeed, such interference constitutes an unacceptable additional cost to employers and reduces profits.

Whilst this is an important viewpoint on labour market regulation, many counter arguments have been marshaled.

First, markets are never perfectly competitive, but are often highly segmented (health is an obvious example). Employers lack many different

kinds of knowledge which would enable them to make "rational" choices. Prejudices frequently override decisions based on economic rationality. Even in competitive markets, discrimination tends to persist and reproduce itself. Second, public sector labour markets (which are particularly important in health care) do not operate on profit-maximizing principles, yet discrimination has been shown to be as pervasive. It has been argued that the labour market simply reflects wider societal patterns of discrimination –stereotyping and competition in themselves will not break these down.

Arguments for policy intervention in this area usually come from three different directions. One is a wider human rights direction, based on an ethical stance on human equality, justice and fair treatment of people regardless of race, gender, age, sexuality etc. Such a stance derives from a profound ethical principle. It does not therefore have to be justified on grounds other than ethics. A pragmatic assertion of this in the context of employment holds that these characteristics are irrelevant to job performance (with some very circumscribed exceptions such as pregnancy or height) and that, on grounds of fairness, employees and would-be employees must be protected against discrimination.

The second direction arises from arguments of cost-effectiveness and efficiency: discrimination represents a cost to employers as they do not necessarily get the best person for the job. There is also a broader argument that there are social and political costs to discrimination that society as a whole has to bear.

The third direction is a form of human capital argument: diversity adds value to a workforce by bringing in a wider range of perspectives and experiences. These latter two propositions are difficult to test empirically, as is the counter argument that anti-discrimination measures constitute an extra cost on employers. Is the appropriate unit of measurement the individual employer, employers as a whole, the national economy? And how can such – often intangible – benefits be measured?

Despite these difficulties, it is probable that a majority of advanced market economies do intervene in some way to promote greater employment equity. Intervention appears to be much less common in poor countries. It is not clear why, but it may be that when set against other social and economic problems and the small size of the formal sector labour force this type of intervention is perceived as a relative luxury.

Approaches to Equity/Anti-Discrimination in Employment Policy

There are several different and to some extent competing schools of thought on how to achieve equity. Some focus more strongly on direct forms of discrimination (e.g. refusal to employ or promote individuals from minorities). Others focus more on indirect forms of discrimination (e.g. unacknowledged assumptions or stereotyping). The main ones are summarized very briefly hereafter:

Equal Opportunities

Discrimination in employment is unfair to those who are not treated on the basis of merit, leads to a waste of resources and can lead to social problems (2). Since the impact and costs of legislation to employers are unknown, action should preferably be by non-legislative means. Preferred actions are: public education and the application of voluntary codes of conduct. Legislation is a resort if these fail. Equal opportunities legislation in some countries (Britain) also disallows unequal treatment of non-minorities, such as men.

"Business Case" Approach

This approach emphasizes the fit between business goals and equality goals. Ethical and cost-effectiveness considerations go together. Equal opportunities policies are bureaucratically cumbersome and too focused on "equal rights". It stresses the "value added" of diversity in the workforce (women's experience in managing multiple responsibilities simultaneously as an excellent basis for management). It stresses the importance of equal opportunities for retaining and motivating qualified staff. Policies reflect a pragmatic concern to retain valuable skilled workers (who may have been trained at considerable cost, or who may be scarce). This approach may involve thinking more imaginatively about the different constraints faced by women in formal employment and about how to provide more employee-friendly terms and conditions. For the public sector, an argument has emerged that the "business case" approach should be transformed into a "quality" approach.

AFFIRMATIVE ACTION

Affirmative action – in which employers take measures to ensure that unintentional discrimination against any group of persons does not occur – is argued to be more proactive than equal opportunities (6). Organisations document the degree to which the availability of qualified people within a certain job category matches their utilization. If an organisation falls short in a category, goals and timetables for reaching those goals are set. Studies of affirmative action have found programmes to be successful at meeting employment targets for minorities, but less so at addressing their retention through equitable career development and reward systems and at tackling more subtle forms of discrimination.

There is some evidence from North America that continuing discrimination and backlash from whites have contributed to job dissatisfaction and turnover among affirmative action groups – but see the defence by Plous (7).

MANAGING DIVERSITY

Organisations should embrace diversity in their workforce and work towards achieving it. Diversity means creating a culture where difference can thrive, rather than working simply for representativeness and assimilation. Managing diversity is concerned mainly with changing individual attitudes rather than with changing organisational structures or processes.

Diversity training programmes have been criticized for focusing on differences between individuals and ignoring institutional structures of discrimination and power relations between majorities and minorities. Diversity management programmes may be most appropriate in contexts where relatively equal groups from different national or cultural backgrounds work together (e.g. pan-European Organisations).

BARRIERS TO ACHIEVING EQUITY IN EMPLOYMENT POLICY

Many barriers are cited in the literature and are relevant to the health sector. In the context of gender, there is a stress on both structural and cultural barriers (11): traditional stereotypes of women and minorities and of what constitutes good managers that hinder progress of the former; work cultures that do not take sexual and racial harassment seriously; general

social attitudes regarding the division of labour that impinge on the workplace; the "gendered" nature of work in the health sector that splits tasks into "female" caring and nurturing ones and "male" technical and managerial ones; the practical problems of lack of childcare; the lack of a "life cycle" perspective on women's needs for flexibility in working hours and career progression (12); where equal opportunities policies are in place, a lack of knowledge of their content and a low level of managerial commitment and resources geared to making these opportunities work; in addition, low pay continues to be a cause of shortages for nursing and paramedical staff, which are heavily dominated by women and often have higher than average numbers of minority employees.

Evidence on Links Between Achieving Equal Opportunities in Employment Practice, Staffing Costs and Outcomes

Three themes emerge from the literature: links between specific employment benefits and staff retention and productivity; links between organisational practices and patient outcomes; indirect links between gender, health providers and health outcomes.

Cox and Blake (13) provide evidence of the benefits to be achieved from what they call 'organisational accommodations' to diversity (i.e. flexibility).

They cite the following results from the United States of America (USA) and the United Kingdom UK (13): absenteeism was reduced by the provision of childcare; both short-term and long-term absenteeism significantly decreased as a result of flexitime; a major UK bank that found investing in childcare led to higher retention rates for staff and that this was cheaper than continually recruiting and training new staff; a UK supermarket chain reported that the number of employees returning to work after maternity leave increased from 42% in 1989/1990 to 74% in 1991/2 as a result of flexible working options. In view of the large sums invested annually in training, there are obvious financial advantages in keeping this trained workforce; in 1989 a pharmaceutical retail chain found that only 4% of their shop assistants returned after maternity leave. By introducing a range of flexible working options the proportion had risen to 49% in 1993.

McKee *et al.* (14) raise issues on the relationship between organisational change and the quality of health care, particularly as regards reforms in the functions and staffing of hospitals. They find that the relationship between staffing and patient outcomes in hospitals is influenced by organisational features affecting what nurses do. For instance, one piece of research identified 39 "magnet" hospitals that were widely regarded by nurses as offering a good environment in which to practice nursing. They were characterised by greater nursing autonomy and better relationships between doctors and nurses and were initially identified in a process that explicitly excluded outcomes. After adjustment for severity of cases, the "magnet" hospitals showed an a lower in-patient mortality rate that was statistically significant (4.6%).

Some work explores a broader set of questions about the relationship between health outcomes and health service provision, which may have an indirect gender component. Robinson & Wharrad (15) use United Nations (UN) data sources to look at the relationship between infant and under-5 mortality rates and the distribution of health professionals. They find a positive association between numbers of health personnel and child survival rates. However, the data do not allow a disaggregation by personnel.

Gender is an important indirect factor in quality of care. In many parts of the world, women users express a wish or need for female practitioners, particularly for MCH level services. This is tacitly recognized in many primary health care programmes and in the recruitment of community health workers. There is scattered evidence that gender plays a role in improving health outcomes. An Ethiopian study notes a statistical correlation between the presence of female members on Local Government Assemblies and female enrolment in schools, immunization of children and antenatal visits by women (16). In Northeast Brazil, the Agentes de Saúde Program (17) employs local female auxiliary health workers very cost effectively to manage basic health care. Since the introduction of the programme in the context of decreased financial support to the public sector, the area has witnessed a rapid decline in infant mortality, a rapid rise in immunization, and the identification of bottlenecks limiting the utilization of other medical resources.

These broader linkages have implications for human resources policies in poor countries in particular and deserve serious exploration.

THE USE OF PERFORMANCE MANAGEMENT TECHNIQUES, PERFORMANCE INDICATORS AND TARGET-SETTING IN RELATION TO ACHIEVING EQUITY IN EMPLOYMENT PRACTICE.

A recent study points out that, whether in private or in public sectors, formal performance management systems have shown very little relationship with quality or patient outcomes (18). Few attempts were found to use performance management explicitly for equity purposes. Hayles (19) describes organisational interventions in other sectors which link managerial pay to diversity actions and results. These interventions reward actions (e.g. training, mentoring, supporting employee resource groups) and measurable results (e.g. improved hiring and retention, positive employee attitudes, reduction in litigation costs) through salary incentives for senior staff. Recent studies are said to have shown a strong correlation between good management diversity practices and profits (19).

Hayles (19) puts forward five key diversity areas for which measurement should be developed: programme evaluation (to link the activity as closely as possible to desired organisational outcomes), representation (the population of the organisation should be studied with respect to the flow of people in, up and out of the organisation and with regard to demographic factors), climate (to determine whether or not the quality of work-life is equitable across groups and individuals), best practice/benchmarks (success in diversity is supported by benchmarking with other organisations to identify best practices) and a link to the overall performance (measurement systems should incorporate elements that examine the relationship between the specific diversity work undertaken and the desired organisational outcomes).

McCourt (20) reviewed the experience of target setting in the UK National Health Service, which was specifically aimed at achieving equitable representation of minority ethnic groups at all levels in order to reflect the ethnic composition of the local population. In 1994, a survey of 285 private and public sector employers found target-setting to be the least successful of all affirmative action initiatives. Although progress was made, targets were not met and key political stakeholders, such as black consultative groups, were alienated.

The UK Department of Health has now produced an equalities framework consultative document for the National Health Service (21). This aims to develop a system-wide approach to planning and evaluating equality. It sets out a common set of standards for equality priorities and targets within an overall performance management framework (see Annex 2 for equalities framework and indicators). Relevant initiatives already in progress include: Sheffield University Early Outreach Scheme – 20 additional places allocated to widen access to medical education for students from schools in deprived areas (no evaluation available); Bradford Job Shop located in an area of ethnic minority concentration to increase representation of ethnic minorities in health work. A "rise" in applications and in workforce representation was noted in the first year; a system-wide rather than single-organisation commitment; backing and resources accompanied by sanctions at senior management level, constitute the most probable factors in success.

Workforce Planning and Workforce Projection Modeling in Relation to Determining and Achieving Gender and Equity Targets

It was not possible to locate many studies or practical examples of health workforce planning and projection models explicitly addressing gender, other minorities and equity targets. Several frameworks acknowledge the need for such targets to be included. For example, Mathews (22), building on the work of Dresang, states that "when used correctly, workforce planning analyzes the skills, retirements, turnover and retention of employees, while considering the balance of social representation and affirmative action.". Attention has mostly been paid to nursing, as a quintessentially female occupation. Buchan (23) examines the role of nursing workforce planning in the context of the UK NHS. He identifies three elements: assessing how many and what type of staff are needed (demand side); identifying how these staff will be supplied (supply side); achieving a balance between the two.

A range of methods is available, none of them exact, as many externalities must be taken into account. Davies (24), also writing about nursing in the NHS, points out that far more is known statistically about doctors than about nurses and that planning models are fairly well

advanced in medicine. In comparison, nurses have been neglected and left to be managed at local level. The statistical base is poor. She attributes this directly to gender bias and the under-valuation of nursing as a female occupation. Both Buchan and Davies concur that workforce planning methods do not recognize the importance of
qualitative differences in the employment patterns and lifetime career needs of women employees (12). Davies provides a critique of the male bias in current planning models (Box 1).

Box 1. Assumptions Built into the Process of Manpower Planning that Give Rise to Difficulty When We Consider Nursing

Entry will follow training; nurses have traditionally been an important part of the labour force while in their initial training…the system is driven by present need for labour, not by any strong notion that labour once trained is a valuable resource to be nurtured; continuous participation; Losses due to a career break and gains due to those returning after a career break will be substantial parts of the overall staffing equation; Losses to the system will be due to retirements (which can be predicted), to job moves (which can be influenced) and to sickness (which will be minimal); commitments to home and family will at certain times in the life-course take priority, the incentives that can be taken for granted for many men - their interest in promotion, their willingness to move and to move their families for career reasons - cannot be assumed to operate in the same way for women; full time working is essential for efficiency and quality; 40% of the NHS nursing workforce is part time – planning should recognize this reality and not treat it as "second best" or women as a "problem".

Davies (24) puts forward the following elements of a woman-friendly approach to workforce planning in nursing: reorganized work schedules/individualized contracts, rather than simply more part time jobs; cost-benefit analysis of different forms of childcare in relation to the real costs of turnover and failures to return; introduction of a concept of the "extended nursing labour force" through the collection of routine data on those working elsewhere and those not working at all, in order to provide accurate information on flows in and out of the pool, nationally, regionally and locally.

Issues of staff retention must be part of workforce planning and projection. For example, there is a very high drop-out rate from nursing in

Zimbabwe among women staff with over 15 years experience. This represents a serious loss of experience and expertise. Planning must examine the reasons for this high exit rate and what is needed to reduce it (25) (Box 2).

Box 2. Data Collection Needs for Gender Equity in Human Resource Planning

Gender blind HRPP can produce discrimination and reduce the effectiveness f human resources. The following areas of potential discrimination are considered in terms of the data collection needs they would generate. For all of them, gender and age disaggregated data on the health sector workforce are required in order to understand its demographic structure, and thus provide a basis for taking account of life cycle factors in the disposition of the workforce.

Terms and conditions for existing staff which set requirements which one sex is less able to meet than the other because of structural or familial constraints (e.g. a promotion requirement for overseas training).

Data on the gender composition of personnel taking up different types of training or career opportunity, data on gender/age of those leaving a) the public sector, b) the health sector. Qualitative data on female and male provider views of opportunities and constraints and on how barriers might be dealt with.

In workforce restructuring, such as the retrenchment of particular cadres of staff who happen to be mainly female.

Data on the gender composition of different categories and grades of workers. Consultation with user and provider stakeholder representatives on implications for service delivery.

In recruitment, where there are significantly lower numbers of women taken on than men.

Quantitative and qualitative data on educational and other barriers to female recruitment. Data on the proportions of men and women in senior positions. Qualitative data from stakeholders on reasons for gender imbalance.

A "category bias" in which a whole group of workers, which happens to be predominantly female, is treated less favourably than another group, which happens to be predominantly male.

Consultation with provider stakeholders on implications of restructuring policies for specific groups and potential for indirect disadvantage, e.g. policies on private practice and professional regulation

SOURCE: Standing H, 2000 (12).

A recent NHS policy document addresses the issue of female "returners" (26). It describes a recruitment drive to get those nurses no longer working in the profession to return. Surveys found that four out of

five nurses no longer working as nurses would come back under the right circumstances. Top priorities for them were personal support and accessible refresher training. Extra money was provided for free "return to practice" courses. This produced a large response. For example, one health care trust provided a 3-week free course, which ran during school hours and attracted returners from a number of hard-to-recruit areas. A majority of the attenders went on to take jobs in the trust, which provides family-friendly employment options, including flexible hours and shifts and school term working, compassionate leave for family emergencies and a workplace nursery.

Some UK NHS Trusts have developed workforce monitoring systems that link information on employees to equal opportunities policies. Key points include the need to have a commitment by senior management, making participation of employees in workforce profiling either compulsory or highly participatory, and ensuring that senior managers and non-executive Board members discuss the information regularly (21).

Canadian policy on employment equity has shifted from an emphasis on meeting numerical targets in "equal opportunities" workforce planning to the provision of fair employment systems and a supportive organisational culture for women, racial minorities, aboriginal peoples and persons with disabilities (27). The new policy requires employers to demonstrate that they are taking action to comply with their own equity plans, that unions and employees are part of the implementation process; it also gives an enforcement role to the Canadian Human Rights Commission.

Methods of Achieving Equity in Career Structures, the Identification of Individual Training and Development Needs and Promotion Opportunities

One gender equity theme recurs over and over in relation to this set of issues. It is the need for flexibility in career planning, coupled with flexible working arrangements for female staff and those with caring responsibilities. Although the documentation of initiatives comes mainly from high income countries and addresses the particular life stage circumstances of women in those countries, the expressed need appears to be universal.

Career structures can be indirectly discriminatory. For instance, imposing a requirement for overseas training created career blocks for

female doctors in the Sudan who were not able to leave husbands and family at that stage in their lives (28). This study found that nearly half of the female medical graduates in the sample were not undertaking postgraduate training. Common forms of discrimination are career paths which penalise those who work part time or those taking time out for family reasons (Box 3).

Box 3. Gender Discrimination in Career Structures

A UK case study of nursing provides an illuminating account of the ways in which the restructuring of a profession dominated by women, without regard to possible gender implications, can operate to disadvantage them. In Britain, nursing historically was not a linear, bureaucratic ladder of opportunity, but a command hierarchy presided over by a (female) matron. This was essentially a female chain of command within the (male) doctor dominated institution of the hospital, which gave the matron sole jurisdiction over her staff of ward sisters and staff nurses.

The health service reforms of the mid-1970s replaced this with a career hierarchy of posts from ward level up through the hospital and through the newly constructed administrative tiers to the Regional Nursing Officer. One result of this was that by the mid-1980s, senior nursing management was increasingly masculinised. Nearly 50% of these posts were held by men, despite the fact that men constitute only 10% of the profession.

This new career hierarchy is described as "stratification on the basis of motherhood." It occurred because of the clash between women's need for career breaks when their children were born, and the rigid logic of career progression where qualifying time periods were built into progression, and "time out" sent a nurse back into a lower grade. There was no allowance for them to remain on the same grade but to work part time. Returning mothers got shunted into what are seen as the "dead zones" such as night work. As night sisters were placed at lower grades than day sisters, it was then difficult to move from nights to days. As a result of this indirect discrimination, whilst men took 8 years on average to reach Nursing Officer grade, women who took career breaks took 23 years.

However, even women with no career breaks took an average of 15 years, suggesting that there were also other discriminatory factors operating. Comments from respondents in the survey suggested a great deal of gender stereotyping. Female nurses were seen as intrinsically not good at management, and as less motivated or concerned with their careers than men. This fed through into e.g. differences in the numbers of women and men applying for promotion at given points in their careers.

SOURCE: Halford S, 1997 (29).

A further kind of indirect discrimination occurs through the setting of rigid boundaries between occupational groups and intra-occupational statuses, for instance, by not allowing paramedical or "certified" staff to improve their skills with formal recognition (30). These groups are mainly female and are more likely to have suffered educational disadvantages related to gender . The strong training and professional divide between doctors and nurses reinforces gender-based stereotyping and discrimination (Tables 1 and 2).

Table 1. Malawi Enrolled and Registered Nurse-Midwives' Perception of the Effect of Being a Woman on Their Careers.

Responses	*RNMs*	*Nurse (N = 145)*	*ENMs*	*Nurse N = 87)*
	Number	Percentage	Number	Percentage
Conflicting maternal and nursing roles	25	17.2	6	6.9
No problems at all	25	17.2	17	19.5
Role overload	14	9.7	7	8.0
Multiple roles; tiresome for nurses; marginalization; decisions not respected; exploitation by men	13	8.9	34	3.9
Enhances a caring attitude	9	6.2	0	0
Gender imbalance on decision making	8	5.5	1	1.1
Professional oppression	5	3.4	3	3.4
Lack of a united voice	5	3.4	0	0
Positively enhances nursing	4	2.8	6	6.9
Depends on reproductive responsibilities	2	1.4	2	2.3
Role confusion	3	2.1	0	0
Not applicable	4	2.8	0	0
Lack of empowerment	2	1.4	0	0
Limited choice, always follows husband	1	0.7	3	3.4
Lack of recognition as nurses	0	0	1	1.1

Table 2. Enrolled and Registered Nurse-Midwives' Perceptions of the Most Pressing Issues in Nursing Today.

Pressing Issues in Nursing Today	*RNMs*	*Nurse (N = 90)*	*ENMs*	*Nurse (N = 100)*
	Number	Percentage	Number	Percentage
Risky work environment	62	68.8	53	53
Scarce material resources	45	50.0	20	20
Heavy workload	44	4.8	53	53
Scarce human resources	38	4.2	35	35
Poor or low salaries	36	3.8	64	64
Poor promotion strategies	28	2.5	19	19
Poor recognition for nurses' contribution to health care	23	2.5	4	4
Limited career development	23	1.7	18	18
Effects of working conditions	16	1.7	4	4
Poor professional image	15	1.6	10	10
Long unsociable hours	14	0.3	6	6
Other reasons	3		3	3

SOURCE: Kaponda C, 1999 (31).

The Ugandan Government's current human resources strategy proposals do not address gender issues directly but their emphasis on creating more open career structures is likely to benefit women. Enrolled nurses are to be upgraded to registered nurse/midwives to enable them to continue providing primary level nursing care. They will be able to develop careers in public health nursing. They can now also be upgraded to medical assistants (who currently are mainly men). Similarly, nursing aides found to be effective will be allowed to enter enrolled nurse training, even though they lack formal educational qualifications. (32).

Current proposals on equal opportunities within the NHS (26) lay down a new career framework for nurses, midwives and health visitors that is designed to provide an open structure with stepping-on and stepping-off points and associated training and professional and personal development (Box 4). These proposals address the fact that the majority of nurses are women and that working conditions need to recognize their roles as primary careers.

The NHS proposals also offer a comprehensive set of measures regarding several aspects of career development and discrimination. These include the significant number of nurses from ethnic minorities, particularly

in the older age groups, together with the very low levels of senior nurses from ethnic minorities; the need to tackle racial and sexual harassment; the need to involve staff in policy-framing. The proposed Framework for Action (21) includes equality standards, indicators and performance management measures for good practice and outcomes (Box 4).

Box 4. A New Career Framework for Nurses, Midwives and Health Visitors for the UK NHS

	Typically people here will, at a minimum be competent...	Typically posts will include…	Typically people here will have been educated and trained to…
Health care assistant	…to provide basic and routine personal care to patients/clients and a limited range of clinical interventions routine to the care setting under the supervision of a registered nurse, midwife or health visitor	…cadets and health care assistants and other clinical support workers	…National Vocational Qualification levels 1,2 or 3
Registered Practitioner	…to do above and exercise clinical judgment and assume professional responsibility and accountability for the assessment of health needs, planning, delivery and evaluation of routine direct care, for both individuals and groups of patients/clients; direct and supervise the work of support workers and mentor students	…both newly registered nurses and midwives and established registered practitioners in a variety of jobs and specialties in both hospital and community and primary care settings.	…higher education diploma or first degree level, hold professional registration and in some cases additional specialist-specific professional qualifications.
Senior Registered Practitioner	…to do above and assume significant clinical or public health leadership of registered practitioners and others, and/or clinical management and/or specialist care	…experienced senior registered practitioners in a diverse range of posts including ward sisters/charge nurses, midwives, health visitors and clinical nurse specialists.	…first or masters degree level, hold professional registration and in many cases additional specialist-specific professional qualifications
Consultant Practitioner	…to do the above and provide expert care, to provide clinical or public health leadership and consultancy to senior	…experienced and expert practitioners holding nurse, midwife or health visitor	…masters or doctorate level, hold professional registration and additional specialist-

	registered practitioners and others and initiate and lead significant practice, education and service development.	consultant posts.	specific professional qualifications commensurate with standards proposed for recognition of a 'higher level of practice'.

SOURCE: (33).

Family-friendly and carer-friendly policies are identified as crucial in retaining and managing staff; Sunderland UK National Health Service Trust, for instance, has a policy called Supporting Carers in Employment, which includes special leave, sickness leave, career breaks, flexitime and job sharing.

Few policies explicitly tackle the issue of promotion, perhaps assuming that if flexible employment policies are in place women and minorities will be promoted more readily. But other barriers are not addressed. For example nurses in Malawi wanted equal opportunities among all health professionals in authoritative positions, so that a nurse or a doctor could both be eligible to head an institution (25).

Entrenched institutional and status barriers between medical and nursing professions continue to be problematic. It is also unclear how decentralization will affect career and promotion opportunities. The Zimbabwe nursing report (31) notes that traditionally work within the public service was always seen as being very secure with a fairly clear career mobility. It provided various career mobility options, such as moving upwards through the districts, and provinces to national level. The decentralized health services do not have the same career mobility prospects. This could make nursing less attractive.

Another less tractable problem is how to tackle the causes and effects of gender stereotyping. The study in Sudan (28) reports complaints of pervasive discrimination against women in promotions and in the award of scholarships for overseas study, with a general assumption that women do not want, or are unable, to advance their careers because of family responsibilities and that women doctors are "inefficient" and lack motivation because they are more likely to work part time or take career breaks (see also 34, 35 on discriminatory selection practices in medicine). This can only be addressed in a much longer timeframe to address and through a concerted effort to move more women into senior management positions. However, Maddock (35) offers a model selection process for all

stages of the selection process, dealing with common forms of discriminatory questioning and methods of discarding candidates, and with ways through which to develop objective person specifications.

This approach could be adapted to other areas of the health sector. Some recent initiatives on widening access to medicine by nurses and others, and on the training together of nurses and doctors may assist in breaking down these more deep-rooted problems (36).

Stereotyping is a symptom of the implicitly "male" nature of career structures and pathways in the health sector. For example, problems of recruiting qualified staff to rural areas and retaining them there are common across the developing world (32). Women health staff are seen as a particular problem in relation to working outside towns or cities. Most attempts to deal with this assume a) that it is best to concentrate on getting staff to spend time in rural areas at the beginning of their careers, and b) that financial incentives or incentives base on career progression work best in motivating employees to move to or stay in rural areas. These assumptions are based on "typical" male career patterns. Yet, in contrast to men, women in early career are generally precisely those most constrained by family and marital demands, or by cultural difficulties in living away from families. A more imaginative approach might test whether and with what incentives older women with no dependent children might be prepared to work for a time in rural areas. There appears to be general agreement that the practical application of equity policies in this broad area is highly dependent on the training and sensitivity of managers who implement them (Box 5).

Box 5. Issues in Managing an Equal Opportunities Policy in a Devolved Setting

These extracts from a case study of an equal opportunities policy for female ethnic minority staff in a UK hospital trust illustrate many of the practical dilemmas of equal opportunities policies in devolved organisations.

General effects of decentralization on equal opportunities

There has been a shift from central bureaucratic control to the devolution of management and budgets to sections and department. Blakemore and Drake (1996) argue that there is evidence that this growth in management discretion can lead to an increase in discrimination, with 'more appointments being made arbitrarily, to greater scope for favouritism in staff promotion, and to the erosion of company-wide equal opportunity standards'.

However, Mason and Jewson (1992) suggest that, despite reservations about increased discretion for individual managers, there may be potential for equal opportunities in this new environment. If equal opportunities policies can be adapted and made to work in devolved units, through winning over senior managers to their merits or ensuring their compliance through incorporating them in their performance targets, then the policies may be more effective and responsive to local conditions and priorities.

Managers and equal opportunities policies in practice

The general uncertainty among managers concerning the hospital's official sexual and racial harassment policy, coupled with a lack of precision about the extent of such harassment and the desire of managers to deal with such matters informally wherever possible, risked leading not only to inconsistency in the handling of cases, but also to a failure to signal to all staff (and patients) that such behaviour will not be tolerated. The overall lack of training in and expert knowledge of equal opportunities among managers only serves to reinforce the restricted attempts that are made to implement innovative and effective equal opportunities policies. Moreover, managers lacking abilities and experience in this area find it especially difficult to raise the profile of equal opportunities policies in general and to press for organisation-wide solutions to related problems.

Training, promotion and career development

Despite being viewed as of great importance by the ethnic minority women employees, in-service training, career development and promotion were marginalised on the equal opportunities agenda by managers.

The women identified a number of barriers to promotion, including structural factors, such as a flat hierarchy, family responsibilities and a lack of confidence in their own abilities. In contrast, the managers in our sample reported that they appointed individuals on ability and that they did not feel that there were any barriers to the promotion of suitably qualified ethnic minority women, and therefore no equal opportunities issues were involved…It is important that the hospital should be as proactive as possible in identifying and encouraging ability, and should not rely alone on individual initiative in seeking promotion.

While for ethnic minority female staff the chief problem associated with training was getting timely information, managers focused on staffing and financial constraints… Behrens (1993) suggests that merely providing training for ethnic minority staff can set them up to fail, unless it is also linked to change in the environment and culture of the organisation.

In general, career advice was offered to those with a 'career' and rarely, if at all, to those with a 'job,' but there was an interest among ethnic minority women currently employed in lower-grade work to progress to work of a higher status.

The 'quality case'

The Commission for Racial Equality, whilst advocating a business case for equal opportunities to the private sector, has modified this to a 'quality case' in the public sector (1995). The 'quality case' consists of enhancing local democracy, accountability and customer satisfaction, understanding customers' needs, using people's talents to the full, becoming an 'employer of choice', enhancing partnership with the private sector and the relationship with central government, and finally, avoiding the legally imposed costs of discrimination.

Recruitment of ethnic minority women

While many [managers at the hospital] favoured increased recruitment of ethnic minority women through advertisements in the local media, particularly the Asian media, there was some resistance towards other examples of positive action and the idea of positive action in principal…Many interviewees argued that greater use should be made by the trust of Asian radio stations and newspapers, as well as advertising in community centres, libraries and shops. Moreover, there was a general feeling among respondents that the trust could do more to provide information to potential applicants about the hospital, its employment conditions, the nature of the job under discussion, and the other kinds of jobs available within the organisation.

SOURCE: Bagilhole B, 1997 (38).

ACHIEVING AND MAINTAINING "GENDER-NEUTRAL" NON-DISCRIMINATORY SYSTEMS FOR THE DETERMINATION OF PAY

Male health personnel have higher average incomes than their female counterparts (39). This is compounded by the high degree of gender segregation in the health workforce, in so far as figures are available. However, this picture does vary internationally (Box 6).

Box 6. Nurses' Remuneration: Female Pay Levels Compared to Male Pay Levels

Job Category	*Sweden*	*United Kingdom*	*Australia*
Health Auxiliary	+ 4%	- 45%	-
Assistant Nurse	+ 0.5%	- 45%	-
Registered Nurse	-	- 21%	+ 1%
Certified Nurse	-	- 21%	+ 23%

SOURCE : Tabulated from Birhaye A, 1994 (40).

The reasons put forward for male advantage include: greater average seniority, faster rates of promotion and wider access to training, longer work hours and greater availability for overtime. This is often in the context of an ostensibly neutral pay system. Clearly, therefore, simply focusing on pay systems will not adequately address differences in remuneration, as these are often tied to the indirect ways in which women are disadvantaged in health employment. There are also intrinsic difficulties in determining what constitutes "non-discrimination" where a high degree of gender segregation exists. Are the generally acknowledged low rates of remuneration in nursing a consequence of the predominantly "female" nature of the occupation, rather than any objective evaluation of the tasks performed? Would increasing the proportion of men in nursing act to raise payment rates, and/or produce widening differentials between men and women within nursing?

Again, whilst a number of countries have broad equal opportunities legislation prohibiting direct discrimination, little evidence was found linking pay systems to equity goals in the health sector. Three issues are potentially relevant to equity: the effects of type of payment system; the linked question of incentives; the implications of decentralized pay and bargaining systems.

McCourt (20) notes that payment systems can be based on job evaluation or on employee performance, or on a mixture of both. Traditionally, health sector pay has been determined by evaluating jobs and tasks (itself a subjective process, given the gender divisions within the health workforce) but there has been increasing interest in many countries in some element of performance-related remuneration. This is linked to recent debates about the lack of incentives linked to improved performance within public sector organisations.

Reviews of performance-related payment systems (28, 41, 42) are equivocal about the benefit of such systems and generally negative about their impact on organisational performance – no link was found between performance-related pay and organisational performance. Concern about gender and the treatment of minorities in such systems relates to the large element of subjectivity entailed in the identification of good performance. Ullrich (41) notes that performance appraisal systems tied to the allocation of merit payments are extremely difficult to render objective and may reinforce existing gender biases in payment systems. This leads to the view

that the critical determinant of performance management success is not the design of the system or the link with pay, but the skill of the managers who operate it, and that organisations should devote their energy to developing managerial skills rather than elaborate payment and appraisal systems. Presumably this should include equal opportunities training and awareness. Again, the evidence on this is lacking.

Whilst the use of incentives for health staff has received some attention in health sector reforms, little attention has been paid to any possible gender dimension. Yet the example of the frequent lament about the difficulty in many countries of getting female staff in particular to work in rural areas suggests that it may be important to find out whether a different incentive structure is needed to attract or retain women. A study in Sudan (28) notes that the primary concern for women doctors in moving to rural areas is adequate housing and security, not salary compensation.

The impact of decentralized payment and bargaining systems on equity does not appear to have been investigated. Nurses in Zimbabwe (31) raised general concerns about the impact of decentralization on nurses' conditions of service. The hypothesis to be tested might run as follows: centralized pay and bargaining systems are more likely to produce equity, since there are greater checks and balances at national level, such as anti-discrimination and human rights legislation, and greater transparency and accountability to key stakeholders such as professional associations.

The counter hypothesis may be; decentralized pay and bargaining can benefit women and other minorities as it encourages disaffected staff to move to areas where pay and conditions are better.

Other Key Organisational Issues

Stakeholder Participation

The importance of consultation and participation by health workers in human resource planning is noted in a number of commentaries, but models to achieve this are lacking. This is an issue not just for individual employees in relation to their organisations, but also for occupational groups as a whole. A recent speech by the Director of Nursing in Zimbabwe makes plain the concerns of nurses: "Any health policy affects the basic operation of all nurses and yet the policy formulation process is an area from which nurses are often excluded. This leads to the development of

feelings of isolation and gender disempowerment." (43). The Director goes on to state that nursing associations have generally found it difficult to assert professional autonomy vis-à-vis the much more powerful doctors' associations, or to be heard in any negotiations. Gender has been an important dynamic in the politics of professional representation, reinforcing the lack of voice of this critical group of health workers. She suggests that influence on policy formulation can be achieved through the following: initiating policy dialogue with stakeholders in the private and public sectors and society at large; conducting policy research to determine future directions in nursing.

HEALTH WORKERS IN THE PRIVATE SECTOR AND INTERNATIONALLY

Most health workforce planning is based implicitly or explicitly on the public sector as the dominant provider, whether of training or of employment. Yet in many countries, particularly low and middle income ones, the private sector is large or even dominant in service provision. This raises many issues from the point of view of equity concerns.

There is much less information on private sector workforce flows, conditions of service and employee experiences of private employers.

The private sector is extremely diverse, encompassing established for-profit providers, non-profit providers such as non-governmental organizations (NGOs) and missions, independent practitioners, and a range of hybrids (e.g. in China where governments fund infrastructure but health workers raise much of their own salaries from service users). We know very little about the implications of this diverse range of provision for managing equity. Is the market a better or worse arbiter of equity? The answer will probably depend on the tightness of labour market conditions.

In countries where the public sector is in financial crisis, there is evidence of an increasing flight to the private sector (25,31). This is not only because of higher salaries but because working conditions are perceived to be better.

There continue to be large-scale movements of health staff across national boundaries. Again, little is known about the equity implications of this. Diversity of employment structures is increasingly likely to be the norm in many countries. More attention will be needed to conditions within these different employment relationships.

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